BACK TO HEALTH WELLNESS CENTER, INC
PATIENT INFORMATION

Please help me provide you with a thorough evaluation by completing all the forms I have given you. All the information you make available will be absolutely confidential.

YOUR NAME		**Today's Date**	
Age **Birth Date**		**S.S.#**	
Street	**City**	**State**	**Zip**
Home Phone	**Cell Phone**		
Email Address			
Marital Status ❑M ❑D ❑W ❑S	**Number of Children** **Ages**		
Emergency Contact:	**Name**	**Phone#**	

Who Are You Here To See? ❑Chiropractor (Dr. Kuskin) ❑Physical Therapist (Karen Philhower)

How did you hear about us? Referred By:_____ ❑Yellow Pages ❑News Paper Ad ❑Sign ❑Internet ❑Insurance Plan/Book ❑Insurance Plan/Internet ❑Google

Name of Insurance company? ❑ N/A

Describe your primary complaint. _____

_____

_____

Who is your primary care physician? _____

Is this your first experience with chiropractic? ❑Yes ❑No ❑NA *If no, when was your last adjustment*_____

How long have you had this condition?_____

What kinds of treatments have you tried?_____

Have you ever been diagnosed with a herniated disc? ❑Yes ❑No What level?_____Date of most recent MRI_____

Has condition been getting better, worse or the same since it began?_____

Have you ever had similar condition in the past? ❑Yes ❑No How often? _____

Accidents or Injuries *(describe; state when occurred)* _____

_____

_____

General	

Occupation _____ Stress Factors ❑physical ❑psychological ❑chemical

Do you follow a regular exercise program? ❑Yes ❑No

Alcohol per day _____	Tobacco per day _____ # of Years _____	Do you have diabetes? ❑Yes ❑No

Recreational Drugs ❑Yes ❑No	Type _____	Quantity _____

Current Conditions	

Please put a check next to any conditions you have experienced within the last 3 months. ***CONTINUED ON BACKSIDE*

General	❑no complaints ❑weakness ❑fatigued ❑fever ❑chills ❑night sweats ❑fainting ❑flushed face

Head	❑no complaints ❑Injuries ❑headaches ❑poor memory ❑dizziness ❑lumps/bumps
Eyes	❑no complaints ❑corrective lenses ❑color blindness ❑eye pain ❑cataracts ❑excessive tearing ❑eye dryness *Date of Last Exam*_____
Nose	❑no complaints ❑bleeding ❑loss of smell ❑nasal discharge ❑post nasal drip ❑sinus surgery
Ears	❑no complaints ❑discharges ❑pain ❑loss of hearing ❑ringing
Mouth/Throat	❑no complaints ❑bleeding gums ❑difficulty swallowing ❑loss of taste ❑ulcers ❑sores ❑TMJ ❑bad breath ❑sore throat ❑hoarsness
Skin and Hair	❑no complaints ❑color changes ❑nail changes ❑hair changes ❑moles ❑rashes ❑sores ❑ ❑hives ❑ulcerations ❑bruise easily ❑recent cuts/bruises
Muscles and Bones	❑no complaints ❑stiff neck ❑pain in neck ❑upper back ❑lower back pain ❑sciatica ❑shoulder ❑elbow ❑hands ❑hips ❑knees ❑foot/ankle ❑muscular pains ❑muscle weakness
Lung *Now or in the past*	❑no complaints ❑asthma ❑trouble breathing ❑coughing with phlegm ❑dry cough ❑chest pain ❑tightness in chest ❑wheezing ❑shortness of breath *Other*_____
Heart *Now or in the past*	❑no complaints ❑high blood pressure ❑low blood pressure ❑open heart surgery ❑aneurysm ❑palpitations ❑varicose veins ❑bleed easily ❑chest discomfort ❑ankle swelling
Digestion System *Now or in the past*	❑no complaints ❑vomiting ❑IBS ❑indigestion ❑distention of abdomen after eating ❑problems with fatty or oily foods ❑constipation ❑diarrhea/loose stools ❑gas
Psychological	❑no complaints ❑loss of control/violence potential ❑depression ❑treated for emotional problems in the past ❑ever considered suicide or attempted suicide ❑easily susceptible to stress
Females Only	

Do you use birth control? ❑Yes ❑No	What type?_____	How long?_____
Painful or tender breasts? ❑Yes ❑No	Do you have breast implants? ❑Yes ❑No	
❑Irregular ❑light ❑heavy menstrual flow? ❑No	Painful Menses? ❑Yes ❑No	
❑Premature Births ❑Miscarriages ❑Abortions? ❑No		
Age menstrual cycle started_____	Age menstrual cycle stopped_____	

Cancer	Have you ever been diagnosed with cancer? ❑Yes ❑No (include skin cancer) When _____	Type and Location	Current Status

Please List Surgeries	_____
_____	
Family Health	
Describe mother's health briefly_____	
Describe father's health briefly _____	

I declare that the information provided on this form is accurate and complete to the best of my recollection. I will inform the doctor if any other facts about my condition come to mind during the time I am in active care at this office.

Signed Date

❑Parent or ❑Guardian

Witness _____

Please List All Prescription Medications You Currently Take:

(continue on back if not enough room)

Name	Dosage	Frequency
Ex. Nexium	20mg Capsule	Once per day

Allergies to Medications:_____

OPEN ENVIRONMENT NOTIFICATION

This office has patients treated in an "open environment" – not behind closed doors (except for chiropractic and massage). Please check here to indicate that you understand and accept this policy. If privacy is an issue, you may discuss this with your treating professional.

☐ **Yes, I understand and accept this policy.**

Patient Signature:_____Date:_____

Print Name:_____

PATIENT PRIVACY

This form states that Back To Health Wellness Center has a patient privacy policy and the patient has been informed that he/she may obtain the complete patient privacy policy at any time.

Patient Signature:_____ Date:_____

Print Name:_____

BACK TO HEALTH WELLNESS CENTER
HIPPA/OSHA POLICY ON ELECTRODES

Please be aware that you may incur a one time $9.00 charge if electrodes are used during therapeutic modalities as prescribed by your healthcare provider. We will house the electrodes for you in the office, but they are yours.

This is not covered by any health insurance program. Please be aware that Back To Health Wellness Center is giving these electrodes to you at cost. We wish to provide you with the best, most sanitary care while conforming to all HIPPA and OSHA requirements.

Sincerely,

Robert I. Kuskin, D .C.
Karen Philhower, P.T.

Please Initial:_____

Back to Health Wellness Center, Inc.

Patient Name:_____Date: _____

Consent for Telephonic or Other Communication

(This consent is intended to satisfy and comply with the requirements of Florida Statute 501.059, if applicable.)

This consent authorizes the following, including, but not be limited to: patient appointment reminders, available appointment openings, urgent notifications regarding changes in office hours (such as inclement weather or illness), or office news. It also includes telephonic sales calls by telephone call, text message, voicemail transmission to deliver or cause to be delivered a telephonic sales call using an automated system for the selection and/or dialing of telephone numbers, the playing of a recorded message when a connection is completed to a number called, or the transmission of a prerecorded voicemail.

By executing this agreement, I hereby authorize Back to Health Wellness Center, Inc. to deliver or cause to be delivered telephonic sales calls to the undersigned at the below telephone number and/or email address using an automated system for the selection and/or dialing of telephone numbers or the playing of a recorded message when a connection is completed to the number called.

Signator is not required to directly or indirectly sign this written agreement or to agree to enter into such an agreement as a condition of purchasing any property, goods, or services.

Signature: _____

Authorized telephone number for calls and texts:_____

Authorized email for communications: _____

OR

I decline to receive phone calls or texts: _____(signature)

I decline to receive emails:_____(signature)

BACK TO HEALTH WELLNESS CENTER
DISCLOSURE & CONSENT FOR
CHIROPRACTIC ADJUSTMENTS AND CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This will allow you to make an informed decision whether or not to undergo the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to treatment.

I request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by Dr. Robert Kuskin and/or other licensed Doctors of Chiropractic working at Back to Health Wellness Center, Inc.. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had or will have the opportunity to discuss with the Dr. Kuskin, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.
I understand, and I am informed that, there are some risks to chiropractic examination and treatment including, but not limited to:

Increased symptoms and pain	fractures (broken bones)
spinal or disc injuries	no improvement of symptoms or pain
dislocations	stroke
sprains/strains	

I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of treatment as to which risks and complications are significant. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had or will have an opportunity to ask questions. All of my questions have or will have been answered to my satisfaction. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition for which I seek treatment.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as:_____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____
witness to patient's signature

_____
translated by

_____
date

_____
date

BACK TO HEALTH WELLNESS CENTER
OFFICE FINANCIAL POLICY

Our policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1) **If you do not have insurance:** All payments are expected at the time of service or on an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. We provide multiple payment options to make care an affordable part of your family budget. If you have a problem with payment please let us know, we will work with you.

2) **If you have insurance:** All deductibles and co-payments are expected at the time of service or on an authorized payment plan. Your co-insurance balance may not exceed $100 at any time or care may be terminated. We provide multiple payment options to make care an affordable part of your family budget. If you have a problem with payment please let us know, we will work with you.

   You are considered a cash patient until your insurance is verified and we get our first explanation of benefits from your insurance company. We will accept assignment for most secondary insurance carriers.

   Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each insurance carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

   If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

   If you discontinue care for any reason other than discharge by the doctor, all balances will become due and payable in full by you, regardless of any claim submitted.

Patient's printed name:_____

Signature:_____ Date:_____

Medicare/Medicare Advantage/Medicare Replacements

*****PLEASE READ AND SIGN*****

Notifier: Robert I. Kuskin, D.C. - 2990 University Parkway – Sarasota, Fl. 34243 – 941-351-2555

Patient Name:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for items listed in D below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **items listed in D below.**

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
New or Established Patient Examination	Not covered when performed by a chiropractor	$74.00
Interferential Therapy	Not covered when performed by a chiropractor	$18.00
Ultrasound/Combo Therapy	Not covered when performed by a chiropractor	$18.00
Massage Therapy (30 minutes)	Not covered when performed by a chiropractor	$40.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the services **listed in D above.**

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the suggested **service listed in D above**. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the suggested **service listed in D above**, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **service listed in D above**. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

Additional Information: The doctors at Back To Health wellness Center, Inc. Will only suggest therapies or services that they feel are necessary to help improve your condition. Please discuss any concerns you have about cost as we strive to eliminate any confusion.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You may ask to receive a copy.

Signature:	Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about- us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.